TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Cy-Fair Pain Intervention

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-3561-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting a medical Fee Dispute Resolution in accordance with 28 TAC 133.307 (c)(2)."

Amount in Dispute: $1300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… The TDI/DWC date stamp lists the received date as 6/26/15 on the requestor's DWC-60 packet, a date greater than one year from 4/3/14 and 5/8/14. The requestor has waived its right to DWC MDR.

… there is a corrected bill for 9/11/14 that shows a change in coding from 99214 to 99213. Texas Mutual has no record of receiving this bill…

Texas Mutual has no record of receiving a bill for date 10/23/14 … No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 3, 2014 May 8, 2014 September 11, 2014 October 23, 2014	Evaluation & Management, established patient (99213, 99215)	$1300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.20 sets out the procedures for medical bill submission.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   For date of service 4/3/14 and 5/8/14:
   - CAC-150 – Payer deems the information submitted does not support this level of service.
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 890 – Denied per AMA CPT Code description for level of service and/or nature of presenting problems.
   - 891 – No additional payment after reconsideration.

Issues

1. Did the requestor waive the right to medical fee dispute resolution?
2. Did the requestor meet the requirements of 28 Texas Administrative Code §133.307 (c)(2)(K) for date of service September 11, 2014?
3. Did the requestor meet the requirements of 28 Texas Administrative Code §133.307 (c)(2)(K) for date of service October 23, 2014?
4. Is the requestor eligible for reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   > Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
   >
   > (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The dispute includes dates of service April 3, 2014 and May 8, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on June 26, 2015. This date is later than one year after the April 3, 2014 and May 8, 2014 dates of service. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section. For this reason, the requestor has waived the right to medical fee dispute resolution regarding these dates of service. These dates of service will not be considered further.

2. 28 Texas Administrative Code §133.307 (c)(2)(K) states that a request for medical fee dispute resolution shall include "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB." The dispute for date of service September 11, 2014 involves CPT Code 99213, as reported on the Medical Fee Dispute Resolution Request (DWC060). Review of the submitted documentation does not find explanations of benefits for this service or convincing evidence of insurance carrier receipt of the request for an EOB. Therefore, the requestor did not meet the requirements of 28 Texas Administrative Code §133.307 (c)(2)(K) for this date of service.

3. The dispute for date of service October 23, 2014 involves CPT Code 99215, as reported on the Medical Fee Dispute Resolution Request (DWC060). Review of the submitted documentation does not find explanations of benefits for this service convincing evidence of insurance carrier receipt of the request for an EOB. Therefore, the requestor did not meet the requirements of 28 Texas Administrative Code §133.307 (c)(2)(K) for this date of service.

4. 28 Texas Administrative Code §133.20 (a) and (c) state, "(a) The health care provider shall submit all medical bills to the insurance carrier except when billing the employer in accordance with subsection (j) of this section… (c) A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills." The submitted documentation does not support that a medical bill for the services in dispute were submitted in accordance with 28 Texas Administrative Code §133.20. Therefore, the requestor is not eligible for reimbursement of the disputed services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	November 6, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.